

# MARYLAND STATE DEPARTMENT OF HEALTH

DEPARTMENT OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

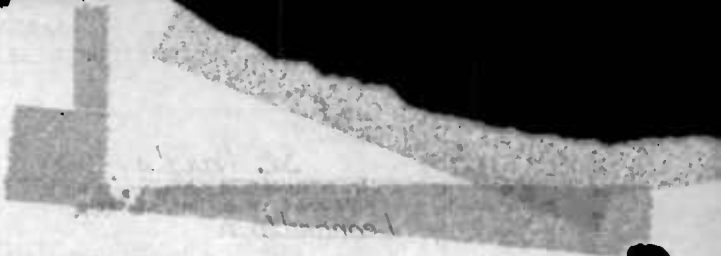
## CERTIFICATE OF DEATH

02682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>				c. LENGTH OF STAY IN 1b <i>1 hr. 55 min.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>St. Mary's Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Wilmer</i> Middle <i>Thaddeus</i> Last <i>Acton</i>			4. DATE OF DEATH Month <i>February</i> Day <i>4</i> Year <i>1966</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 28, 1900</i>		9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>05</i> Days <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John T. Acton</i>				14. MOTHER'S MAIDEN NAME <i>Annie Lee LaMarr</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Mrs Stager Laurel Spring, New Jersey</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X Coronary thrombosis</i> DUE TO (b) <i>atherosclerotic disease</i> DUE TO (c) <i>Diabetes Mellitus</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (II) (we) last saw the deceased alive on <i>2-9-67</i> 19 <i>67</i> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <i>J. Roy Guyther</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>J. Roy Guyther M. D.</i>				22d. ADDRESS <i>Mechanicville, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-9-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Old Fields</i>		23d. LOCATION (City, town or county) (State) <i>Hughesville Md.</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 9 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

38850



Chinese Nationalist Government, Republic of China

... ..

... ..

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02687

CERTIFICATE OF DEATH

02683

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - DAMERON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>		d. STREET ADDRESS <b>18-1</b>	
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>AGATHA</b> Last <b>BISCOE</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/1892</b>
9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DANIEL F. HAMMETT</b>		14. MOTHER'S MAIDEN NAME <b>IDA I. BOHANAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212 56 2378</b>	
17. INFORMANT <b>MR. DANIEL B. BISCOE</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO (b) DUE TO (c) <b>Circulatory Collapse Myocardial Infarction Spontaneous Aortic Dissection</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b> <b>hrs</b> <b>hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1967</b> to <b>2/10 1967</b> , that (I) <b>last</b> saw the deceased alive on <b>2/10 1967</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>J. P. JARBOE</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. P. JARBOE M.D.</b>		22b. DATE SIGNED <b>2/13/67</b>	
22d. ADDRESS <b>GREAT MILLS, MARYLAND</b>		22e. ADDRESS <b>GREAT MILLS, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. JAMES CEM.</b>		23d. LOCATION (City, town or county) (State) <b>Clark Hall Md</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WELCH</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 16 1967</b>	

05083

72230

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "SYNOPSIS" and "REMARKS" are faintly visible.]*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02684

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clements</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clements</u> <u>18-1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Michael James Edward Brown</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1935</u>		9. AGE (In years last birthday) yrs. <u>31</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James William Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lillian Herbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary Virginia Brown Clements, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>8254</u> IMMEDIATE CAUSE (a) <u>Intra Cranial Trauma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> <u>2-26</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 242</u>		20f. (City or town) (County) (State) <u>Clements St Marys Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W.D. Boyd</u> M.D.				22. DATE SIGNED <u>2-26-67</u>			
EXAMINER'S NAME (Type) <u>William D. Boyd M. D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		23d. LOCATION (City or Town) (County) (State) <u>Bushwood, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

02884

02884

14. 1987

14. 1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987

1987



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02689

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02685

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtoun</u>		c. LENGTH OF STAY IN lb <u>90 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clements</u> <u>18-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Xavier</u> Last <u>Carter</u>			4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1938</u>		9. AGE (In years last birthday) <u>28</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph I. Carter</u>			14. MOTHER'S MAIDEN NAME <u>Mary Catherine Thomas</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-4723</u>		17. INFORMANT <u>Barbara A. Carter</u> Address <u>5101 2nd Street N. W. Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>8254</u> IMMEDIATE CAUSE (a) <u>Subdural Hematoma</u> DUE TO (b) <u>Fracture of elbow</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>auto accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture of elbow</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident</u>			
21c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00 pm</u> <u>2-26</u> 19 <u>67</u>		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 242</u>	
21f. (City or town) <u>Clements</u>		21g. (County) <u>St Marys</u>		21h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>William D. Boyd</u>		M.D. <u>William D. Boyd M. D.</u>		22. DATE SIGNED <u>2-26-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	
23d. LOCATION (City or Town) <u>Bushwood</u>		23e. (County) <u>Maryland</u>		23f. (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtoun, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

76

2

18

2

AP

03230

03230

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967



12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967

12. 1967



FOR STATE  
HEALTH DEPT.

02690

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02686

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chaptico - rural</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chaptico</b> 18-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Anne Dorothea Davis</b>				4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>19 67</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1898</b>		9. AGE (In years last birthday) <b>65 68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chaptico, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Edward Davis</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Burgess</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Kenneth L. Davis</b> Address <b>1805 N. Quinn St. Arlington, Virginia</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia and purulent bronchitis</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>2/24/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Chaptico, St. Mary's, Md.</b>	
24. FUNERAL DIRECTOR <b>W. Clarke Mattingley Leonardtown, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

032886

032886

Medical Report Form  
Patient Name: [illegible]  
Date: [illegible]  
Time: [illegible]  
Location: [illegible]  
Referral: [illegible]  
History: [illegible]  
Physical Exam: [illegible]  
Diagnosis: [illegible]  
Treatment: [illegible]  
Prognosis: [illegible]  
Signature: [illegible]  
Date: [illegible]

FOR STATE HEALTH DEPT.

02691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02687

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Valley Lee</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Valley Lee</i>	
c. LENGTH OF STAY IN lb <i>Life</i>		d. STREET ADDRESS <i>18-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Franklin</i> Last <i>Fenwick</i>		4. DATE OF DEATH Month <i>February</i> Day <i>4</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 14, 1965</i>
9. AGE (In years last birthday) yrs. <i>1</i>		10. IF UNDER 1 YEAR Months <i>9</i> Days <i>20</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Andrew Fenwick</i>		14. MOTHER'S MAIDEN NAME <i>Mary Catherine Young</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mary C. Fenwick</i>		Address <i>Valley Lee, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Burns Extreme</i> DUE TO <i>916.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>House fire</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>5:00</i> <i>2-4</i> 19 <i>67</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Valley Lee St Marys Md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i> M.D.		22. DATE SIGNED <i>2/6/67</i>	
EXAMINER'S NAME (Type) <i>William D. Boyd M. D.</i>		Address (Street, city, town, or county) <i>Valley Lee, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Feb. 6, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Our Lady's Chapel</i>	23d. LOCATION (City or Town) (County) (State) <i>Medley's Neck Maryland</i>
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>		25. REC'D BY REGISTRAR DATE <i>FEB 9 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05282

05282

1. The first part of the report is a general description of the area. It is a small, flat, open area with a few scattered trees and shrubs. The soil is sandy and the vegetation is sparse. The area is located in the north-east corner of the plot.

2. The second part of the report is a detailed description of the vegetation. It is a list of the plants and animals found in the area. The plants are mostly grasses and small shrubs. The animals are mostly insects and small mammals.

3. The third part of the report is a description of the soil. It is a sandy soil with a high water table. The soil is very dry and the water table is very low.

4. The fourth part of the report is a description of the climate. It is a hot, dry climate with a high temperature and low humidity. The temperature is usually between 80 and 90 degrees Fahrenheit. The humidity is usually between 20 and 30 percent.

5. The fifth part of the report is a description of the water. It is a small, shallow pond with a high water table. The water is very clear and the water table is very low.

6. The sixth part of the report is a description of the land use. It is a small, flat, open area with a few scattered trees and shrubs. The land is used for agriculture and the water is used for irrigation.

7. The seventh part of the report is a description of the land ownership. It is a small, flat, open area with a few scattered trees and shrubs. The land is owned by the government and the water is owned by the state.

8. The eighth part of the report is a description of the land management. It is a small, flat, open area with a few scattered trees and shrubs. The land is managed by the government and the water is managed by the state.

9. The ninth part of the report is a description of the land conservation. It is a small, flat, open area with a few scattered trees and shrubs. The land is conserved by the government and the water is conserved by the state.

10. The tenth part of the report is a description of the land restoration. It is a small, flat, open area with a few scattered trees and shrubs. The land is restored by the government and the water is restored by the state.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02692					02688						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY <i>St. Mary's</i> MARYLAND					a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Leonardtoun</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Leonardtoun</i>						
c. LENGTH OF STAY IN 1b <i>6 days</i>					d. STREET ADDRESS <i>Rt. 1 Box 88</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>St. Mary's Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First <i>Mary</i> Middle <i>Josephine</i> Last <i>Goddard</i>			Month <i>February</i> Day <i>1</i> Year <i>1967</i>			<i>Female</i>		<i>White</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>June 21, 1894</i>			9. AGE (In years last birthday) <i>72</i> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>					11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>Joseph Samuel Spalding</i>					14. MOTHER'S MAIDEN NAME <i>Ruth Payne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes give war or dates of service)</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Alice Regina Abell</i> Address <i>Leonardtoun, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture Myocardium</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i>											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John F. Fenwick</i>					22b. DATE SIGNED <i>2/2/67</i>						
22c. PHYSICIAN'S NAME (Type) <i>John F. Fenwick M.D.</i>					22d. ADDRESS <i>Leon</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>Feb. 4, 1967</i>						
23c. NAME OF CEMETERY OR CREMATORY <i>Our Lady's Chapel</i>					23d. LOCATION (City, town or county) (State) <i>Medley's Neck, Maryland</i>						
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>					25a. REC'D BY REGISTRAR <i>1967</i>						
ADDRESS <i>Leonardtoun, Maryland</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

BP

02888

02888

John F. French M.D. 1888



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76

2

1

BP

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02693

CERTIFICATE OF DEATH

02689

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN 1b <i>21 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>St. Mary's Hospital</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Valley Lee</i> <i>18.1</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Gwynette</i> Last <i>Goldsborough</i>		4. DATE OF DEATH Month <i>February</i> Day <i>2</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 4, 1875</i>
9. AGE (in years last birthday) <i>91</i> yrs.		10. IF UNDER 1 YEAR Months <i>91</i> Days <i>91</i> Hours <i>91</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Steven Russell</i>		14. MOTHER'S MAIDEN NAME <i>Alice Cecil</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> <i>331X</i> DUE TO <i>Senility - arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured left hip -</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <i>A. Samad</i> <i>P. J. Samad M.D.</i>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>P. J. Samad M.D.</i>			
22d. ADDRESS <i>Leonardtown, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			
23b. DATE THEREOF <i>Feb. 4, 1967</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cemetery</i>			
23d. LOCATION (City, town or county) (State) <i>Hollywood, Maryland</i>			
24. FUNERAL DIRECTOR <i>W. Clarke Marringley Leonardtown, Maryland</i>			
25a. REC'D BY REGISTRAR <i>FEB 6 1967</i>			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



02694

## CERTIFICATE OF DEATH

02690

1. PLACE OF DEATH a. COUNTY <u>St. Mary's County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>		c. LENGTH OF STAY IN lb <u>1 1/2 years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital NAS PaxRiv, MD.</u>		d. STREET ADDRESS <u>511 Hancock Road</u> <u>Lexington, Park, Maryland.</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence Lee Gordon</u>		4. DATE OF DEATH <u>February 8,</u> 19 <u>67.</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 22, 1931</u> 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN 1951</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Missouri</u>	
13. FATHER'S NAME <u>Hollis Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Corine Passmore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1951 - 1967</u>		16. SOCIAL SECURITY NO. <u>498 22 6705</u>	
17. INFORMANT <u>Wife.</u>		Address <u>311 Hancock, Park, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7 FEB 67, 19 67</u> , to <u>8 FEB 19 67</u> , that (I) (we) last saw the deceased alive on <u>8 FEB 19 67</u> , and that death occurred at <u>0030</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>I. J. MILLER, LT MC USN</u>		22b. DATE SIGNED <u>8 FEB 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. J. MILLER, LT MC USN</u>		22d. ADDRESS <u>Station Hospital, NAS PAX RIV M</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEBSO

Deaso

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02695					02691				
1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN 1b <b>LEONARDTOWN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - LEONARDTOWN</b> d. STREET ADDRESS <b>RT. 1 RIVERSIDE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>THABET</b> Last <b>HANNEN</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>8</b> Year <b>19 67</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/26/1900</b>		9. AGE (In years last birthday) <b>66</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED (PHYSICIST)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US CIVIL SERVICE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JOSEPH H. HANNEN</b>				14. MOTHER'S MAIDEN NAME <b>PAULINE KNOBLOCH</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W W II 265 40 1104</b>		17. INFORMANT <b>MRS. ELEANOR R. HANNEN</b>		Address <b>SAME AS #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardio Vascular Renal Disease 5 years.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>LEXINGTON PARK, MARYLAND</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 8, 1967</b> , to <b>Feb. 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 8, 1967</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>WM. H. PATRICK</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-10-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>WM. H. PATRICK M.D.</b>				22d. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE'S EPIS. CEM.</b>		23d. LOCATION (City, town or county) (State) <b>VALLEY LEE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>JOHN M. WELCH - LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10050

10050



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02692											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Scotland Leonardtown</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Scotland Rural</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Mary's Hospital</u>					d. STREET ADDRESS <u>181</u>						
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Webster</u> Last <u>Knott</u>					4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 27, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>St. Mary's Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Henry Knott</u>					14. MOTHER'S MARDEN NAME <u>Anna Goddard</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>217-09-6501</u>		17. INFORMANT <u>Ruth Elizabeth Knott</u>			Address <u>Scotland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brachpneumonia</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>days</u> <u>hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>1964</u> to <u>2/8, 1967</u> that (I) <u>met</u> last saw the deceased alive on <u>2/8, 1967</u> and that death occurred at <u>4 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>James P. Jarboe M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/8/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>James P. Jarboe M.D.</u>					22d. ADDRESS <u>Great Mills, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>				
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>					ADDRESS <u>Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

02020

02020

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02697					02693					
1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtoun</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colton Point</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>St. Mary's Hospital</i>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Peter</i> Middle <i>Knowles</i> Last <i>Knowles</i>			4. DATE OF DEATH Month <i>February</i> Day <i>6</i> Year <i>1967</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 10, 1897</i>		9. AGE (In years last birthday) <i>69</i> IF UNDER 1 YEAR: Months <i>6</i> Days <i>18</i> Hours <i>1</i> Min. <i>1</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales representative</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Florida</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William H. Knowles</i>					14. MOTHER'S MAIDEN NAME <i>Mary Ellis</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i> <i>WW I</i>			16. SOCIAL SECURITY NO. <i>207-10-1694</i>		17. INFORMANT <i>Anne C. Knowles</i>			Address <i>Colton Point, Maryland</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio vascular renal disease</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Polycythemia - rectal polyps</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)						
21. I certify that (I) (this hospital) attended the deceased from <i>1/20/67</i> , 19 <i>67</i> , to <i>Feb 6</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Feb 6</i> , 19 <i>67</i> , and that death occurred at <i>3 P</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>William D. Boyd</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/10/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>William D. Boyd M. D.</i>					22d. ADDRESS <i>Leonardtoun, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 8, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Oakley, St. Mary's, Maryland</i>				
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>					ADDRESS <i>Leonardtoun, Maryland</i>		25a. REC'D BY REGISTRAR <i>FEB 14 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

02030

THE STATE OF CALIFORNIA

1930

Section 10

Section 10

Section 10

Section 10

Section 10

Section 10

Section 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02698					02694						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						
ST. MARYS MARYLAND					MARYLAND ST. MARYS						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
LEONARDTOWN					LEONARDTOWN						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
ST. MARYS HOSPITAL					BOX 221						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH Month Day Year		
ALVIN			FRANCIS		NELSON JR.		FEB.		2 19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCT. 9, 1938		28 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
CASHIER				SAFeway FOOD STORE		MARYLAND			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
ALVIN FRANCIS NELSON SR.						FRANCES LOUISE LONG					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO				219 36 9873		ALVIN FRANCIS NELSON SR.		SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5702 Diffuse gangrene of the small bowel Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Thrombosis of the mesenteric DUE TO (c) <del>Dissection</del> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1967 to Feb 2, 1967, that (I) (we) last saw the deceased alive on Feb 2, 1967, and that death occurred at 5:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE A. Samadi						22b. DATE SIGNED 2/3/67			22c. PHYSICIAN'S NAME (Type) A. SAMADI M.D.		
22d. ADDRESS LEONARDTOWN, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 2/4/67		23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEM.			23d. LOCATION (City, town or county) (State) LEONARDTOWN, MD.		
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.						25a. REC'D BY REGISTRAR FEB 6 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

APASO

READ



2  
3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02693					02695				
1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Lexington Park</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural St. George Island 18-1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ruth</i> Middle <i>B.</i> Last <i>Rice</i>			4. DATE OF DEATH Month <i>February</i> Day <i>26</i> Year <i>19 67</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 26, 1896</i>		9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Barbara R. McCabe 17 Lei Drive Lex. Pk. Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>170X</i> IMMEDIATE CAUSE (a) <i>Mitotic carcinoma of lungs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Carcinoma of breast</i> (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>4 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 18, 1962</i> to <i>Feb 26, 1967</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Feb 26, 1967</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>P. J. Bean</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/27/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>P. J. Bean M. D.</i>				22d. ADDRESS <i>Great Mills, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 2, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. George Island M.E.</i>		23d. LOCATION (City, town or county) (State) <i>St. George Island, Md.</i>			
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>				25a. REC'D BY REGISTRAR <i>DATE FEB 28 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

2250

20230

Page 52

6.1.2004

2

1529

2

Examiner of death  
Potatoes various of size

25

— 231 —

10. *Chrysomelids*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02700					CERTIFICATE OF DEATH					02696				
1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>					c. LENGTH OF STAY IN 1b <i>D.O.A.</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Valley Lee</i> <i>18-1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>St. Mary's Hospital</i>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Frank</i> Last <i>Slade Jr.</i>					4. DATE OF DEATH Month <i>February</i> Day <i>15</i> Year <i>1967</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 10, 1921</i>		9. AGE (In years last birthday) <i>45</i> yrs.		IF UNDER 1 YEAR Months <i>45</i> Days <i>15</i> Hours <i>15</i> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>John Frank Slade Sr.</i>					14. MOTHER'S MAIDEN NAME <i>Maud Isabelle Rauls</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or dates of service)					17. INFORMANT <i>Marion G. Slade</i> Address <i>Valley Lee, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4201</i> DUE TO (b) <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <i>yr.</i>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that (I) (the hospital) attended the deceased from <i>1955</i> , to <i>2/15</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2/15</i> , 19 <i>67</i> , and that death occurred at <i>8A</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>James P. Jarboe</i>					22b. DATE SIGNED <i>2/16/67</i>					22c. PHYSICIAN'S NAME (Type) <i>James P. Jarboe M. D.</i>				
22d. ADDRESS <i>Great Mills, Maryland</i>					23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>									
23b. DATE THEREOF <i>2/18/67</i>					23c. NAME OF CEMETERY OR CREMATORY <i>St. Leo's Episcopal</i>					23d. LOCATION (City, town or county) (State) <i>Valley Lee Md.</i>				
24. FUNERAL DIRECTOR <i>McCluskey Mattingly</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE <i>FEB 20 1967</i>														

02350

02350

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

1941.12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02701					02697				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <i>St. Mary's</i> MARYLAND					a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Leonardtoun</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Abell</i> <i>18-1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>St. Mary's Hospital</i>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <i>Mary</i> Middle <i>Margaret</i> Last <i>Tate</i>		4. DATE OF DEATH		Month <i>February</i> Day <i>13</i> Year <i>19 67</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 12, 1885</i>		9. AGE (In years last birthday) <i>81</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Tate</i>					14. MOTHER'S MAIDEN NAME <i>Susan Regina Hardin</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i>577-01-9377</i>		17. INFORMANT Address <i>Mrs Clem Beitzell Abell, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Hypertensive Cardis</i> DUE TO (c) <i>Vascular Disease</i>								INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>50%.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <i>John F. Fenwick</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2-14-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>John F. Fenwick M. D.</i>					22d. ADDRESS <i>Leonardtoun, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Feb. 15, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>		23d. LOCATION (City, town or county) (State) <i>Bushwood, Maryland</i>		
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>					ADDRESS <i>Leonardtoun, Maryland</i>		25a. REC'D BY REGISTRAR <i>W. Clarke Mattingley</i>		25b. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley</i>
					DATE <i>FEB 15 1967</i>				

100

61. 10. 32.

*Indigotricha* n. sp., 52.

1971, 1972, 1973

*[Faint handwritten text at the bottom of the page]*

101.51.5

James, William, 1890-1902



4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00

2

1

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02702  
CERTIFICATE OF DEATH  
02698

1. PLACE OF DEATH a. COUNTY <u>Leonardtown St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u>			
c. LENGTH OF STAY IN IB <u>Life</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Susan</u> Last <u>Wathen</u>				4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9, 1877</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John H. Wathen</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>212-56-0150</u>		17. INFORMANT <u>Mrs Louise Wehrmann</u> Address <u>Leonardtown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 444X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility &amp; Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>67</u> , to <u>2/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles Greenwell</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Greenwell M. D.</u>				22d. ADDRESS <u>Leonardtown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Leonardtown, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR <u>Feb 20 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	

1. The first of these is the fact that the  
2. second is the fact that the  
3. third is the fact that the  
4. fourth is the fact that the  
5. fifth is the fact that the  
6. sixth is the fact that the  
7. seventh is the fact that the  
8. eighth is the fact that the  
9. ninth is the fact that the  
10. tenth is the fact that the  
11. eleventh is the fact that the  
12. twelfth is the fact that the  
13. thirteenth is the fact that the  
14. fourteenth is the fact that the  
15. fifteenth is the fact that the  
16. sixteenth is the fact that the  
17. seventeenth is the fact that the  
18. eighteenth is the fact that the  
19. nineteenth is the fact that the  
20. twentieth is the fact that the  
21. twenty-first is the fact that the  
22. twenty-second is the fact that the  
23. twenty-third is the fact that the  
24. twenty-fourth is the fact that the  
25. twenty-fifth is the fact that the  
26. twenty-sixth is the fact that the  
27. twenty-seventh is the fact that the  
28. twenty-eighth is the fact that the  
29. twenty-ninth is the fact that the  
30. thirtieth is the fact that the  
31. thirty-first is the fact that the  
32. thirty-second is the fact that the  
33. thirty-third is the fact that the  
34. thirty-fourth is the fact that the  
35. thirty-fifth is the fact that the  
36. thirty-sixth is the fact that the  
37. thirty-seventh is the fact that the  
38. thirty-eighth is the fact that the  
39. thirty-ninth is the fact that the  
40. fortieth is the fact that the  
41. forty-first is the fact that the  
42. forty-second is the fact that the  
43. forty-third is the fact that the  
44. forty-fourth is the fact that the  
45. forty-fifth is the fact that the  
46. forty-sixth is the fact that the  
47. forty-seventh is the fact that the  
48. forty-eighth is the fact that the  
49. forty-ninth is the fact that the  
50. fiftieth is the fact that the  
51. fifty-first is the fact that the  
52. fifty-second is the fact that the  
53. fifty-third is the fact that the  
54. fifty-fourth is the fact that the  
55. fifty-fifth is the fact that the  
56. fifty-sixth is the fact that the  
57. fifty-seventh is the fact that the  
58. fifty-eighth is the fact that the  
59. fifty-ninth is the fact that the  
60. sixtieth is the fact that the  
61. sixty-first is the fact that the  
62. sixty-second is the fact that the  
63. sixty-third is the fact that the  
64. sixty-fourth is the fact that the  
65. sixty-fifth is the fact that the  
66. sixty-sixth is the fact that the  
67. sixty-seventh is the fact that the  
68. sixty-eighth is the fact that the  
69. sixty-ninth is the fact that the  
70. seventieth is the fact that the  
71. seventy-first is the fact that the  
72. seventy-second is the fact that the  
73. seventy-third is the fact that the  
74. seventy-fourth is the fact that the  
75. seventy-fifth is the fact that the  
76. seventy-sixth is the fact that the  
77. seventy-seventh is the fact that the  
78. seventy-eighth is the fact that the  
79. seventy-ninth is the fact that the  
80. eightieth is the fact that the  
81. eighty-first is the fact that the  
82. eighty-second is the fact that the  
83. eighty-third is the fact that the  
84. eighty-fourth is the fact that the  
85. eighty-fifth is the fact that the  
86. eighty-sixth is the fact that the  
87. eighty-seventh is the fact that the  
88. eighty-eighth is the fact that the  
89. eighty-ninth is the fact that the  
90. ninetieth is the fact that the  
91. ninety-first is the fact that the  
92. ninety-second is the fact that the  
93. ninety-third is the fact that the  
94. ninety-fourth is the fact that the  
95. ninety-fifth is the fact that the  
96. ninety-sixth is the fact that the  
97. ninety-seventh is the fact that the  
98. ninety-eighth is the fact that the  
99. ninety-ninth is the fact that the  
100. hundredth is the fact that the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02703

CERTIFICATE OF DEATH

02699

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b <b>18-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>				d. STREET ADDRESS <b>CHARLOTTE HALL</b>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>ARTHUR</b> Last <b>WOOD</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>25</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/15/1880</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>25</b> Days <b>18</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Months <b>25</b> Days <b>18</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>HENRY E. WOOD</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA THOMPSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>JOS. SCHIMDT WOOD - CHARLOTTE HALL, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>year</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>60</b> , to <b>Feb</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb 25</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>David Mossman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID MOSSMAN M.D.</b>				22d. ADDRESS <b>MECHANICSVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS CE.</b>		23d. LOCATION (City, town or county) (State) <b>LEONARDTOWN, MD.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>MAR 2 1967</b>							

02889

DEPARTMENT OF HEALTH

02889

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*